

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
 PARTS I & II

INTERMEDIARY [] AUDITED DATE RECEIVED [] INITIAL [] RE-OPENING
 USE ONLY: [] DESK REVIEWED INTERMEDIARY NO. [] FINAL [] MCR CODE

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 05/15/2009
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 14:44

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HEALTHSOUTH DEACONESS REHAB (15-3025) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2008 AND ENDING 12/31/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 05/15/2009 14:44
 YbvOSE:rKzhZlgIA44TdVilO5auki0
 RWxmq0.astIyO4MklJes2hr8i5ePAC
 f6UV0p0FM30Ra8oV

(SIGNED) Rob Wisner
 OFFICER OR ADMINISTRATOR OF PROVIDER
ROB WISNER SVF-REIMBURSEMENT

TITLE
MAY 19 2009
 DATE

PI Encryption: 05/15/2009 14:44
 bLEJA.ZCsUeOuwFejnFjRfNgfN3f0
 LC2fi0nVvtDL5T.KHw8:A2Zcf8hmJ
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PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	-58033		150002	2
3	SWING BED - SNF				3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	HEALTH CLINIC				9
100	TOTAL	-58033		150002	100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.



MEDICARE COST REPORT INFORMATION PACKAGE

CERTIFICATION SHEET

This sheet must be completed and signed in order for the Medicare Information Package to be considered complete. A MEDICARE COST REPORT WILL NOT BE FILED IF THE CERTIFICATION SHEET IS NOT COMPLETED, AND SIGNED. Failure to file a cost report may result in a suspension of payments to the hospital, and could ultimately lead to a recoupment of all Medicare payments received, as well as termination of the hospital's provider agreement.

Hospital Name: HEALTHSOUTH/DEACONESS, LLC

Medicare Provider #: 15-3025

Medicare FYE: DECEMBER, 2008

I hereby certify that I have examined the accompanying Medicare Information Package and to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the records of the reporting entity.

I further certify that there were no expenditures of a personal nature included in the facilities books, or if there were, they are disclosed below. Additionally, I certify that no expenditures were made to induce referrals.

I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the Medicare Information Package were provided in compliance with such laws and regulations.

Only for Florida facilities: I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services were provided in compliance with such laws and regulations.

BARB BUTLER
Administrator Printed Name

Barbara Butler
Administrator Signature

1/21/09
Date

Comments:

I have used data from the financial statements supplied by the Corporate Office in Birmingham, AL, in completion of the Medicare information package.

As reported by the Company, the United States Securities and Exchange Commission ("SEC"), Department of Justice ("DOJ"), Department of Health and Human Services Office of the Inspector General ("OIG"), and the Committee on Energy and Commerce of the United States House of Representatives ("House") are investigating the financial accounting and related activity of the Company. As a result of these investigations, the Company's financial statements cannot be relied upon. The Company has engaged forensic accountants to review its financial statements, and has retained a new registered public accountant to re-audit and report upon its financial statements. If, as a result of that forensic review and re-audit, any adjustments of hospital and/or home office cost reports are required, amended cost reports will be filed.



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Hospital Name: HEALTHSOUTH/DEACONESS, LLC

Medicare Provider #: 15-3025

Medicare FYE: DECEMBER, 2008

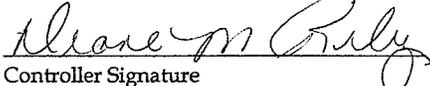
I hereby certify that I have examined the accompanying Medicare Information Package and to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the records of the reporting entity.

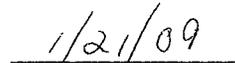
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Only for Florida facilities: I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services were provided in compliance with such laws and regulations.

DIANE RILEY
Controller Printed Name


Controller Signature


Date

Comments:

I have used data from the financial statements supplied by the Corporate Office in Birmingham, AL, in completion of the Medicare information package.

As reported by the Company, the United States Securities and Exchange Commission ("SEC"), Department of Justice ("DOJ"), Department of Health and Human Services Office of the Inspector General ("OIG"), and the Committee on Energy and Commerce of the United States House of Representatives ("House") are investigating the financial accounting and related activity of the Company. As a result of these investigations, the Company's financial statements cannot be relied upon. The Company has engaged forensic accountants to review its financial statements, and has retained a new registered public accountant to re-audit and report upon its financial statements. If, as a result of that forensic review and re-audit, any adjustments of hospital and/or home office cost reports are required, amended cost reports will be filed.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 4100 COVERT AVENUE

1.01 CITY: EVANSVILLE

STATE: IN

P.O. BOX:

ZIP CODE: 47714

COUNTY: VANDERBURGH

1

1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P, T, O OR N)			
				V 4	XVIII 5	XIX 6	
2	HOSPITAL	15-3025	06/08/1989	N	P	O	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF						4
5	SWING BEDS - NF						5
6	HOSPITAL-BASED SNF						6
7	HOSPITAL-BASED NF						7
8	HOSPITAL-BASED OLTG						8
9	HOSPITAL-BASED HHA						9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC						14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16
17	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 01/01/2008 TO: 12/31/2008				17
18	TYPE OF CONTROL		1 5	2			18
	TYPE OF HOSPITAL/SUBPROVIDER						
19	HOSPITAL						19
20	SUBPROVIDER I		5				20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.						21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?		NO				21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.						21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.		1 N		Y 21780		21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.		1				21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.		1				21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.		NO				21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?		NO				22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW		NO				23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.						23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL. 2 AND TERMINATION IN COL. 3.						24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.						24.01
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?		NO				25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?		NO				25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.		NO				25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.		NO				25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2		NO				25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)		NO		NO		25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)		NO		NO		25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES:	BEGINNING:	ENDING:		26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):	BEGINNING:	ENDING:		26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.			NO	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)					
28.03	STAFFING				
28.04	RECRUITMENT	0.00		N	28.03
28.05	RETENTION OF EMPLOYEES	0.00		N	28.04
28.06	TRAINING	0.00		N	28.05
28.07	OTHER (SPECIFY)	0.00		N	28.06
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?			NO	29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.			NO	30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.				30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?				30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)				30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.				30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).			NO	31
MISCELLANEOUS COST REPORTING INFORMATION					
32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.			NO	32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.			NO	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?			NO	34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?			NO	35
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	V	XVIII	XIX	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	1	2	3	
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	YES	NO	36
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	36.01
		NO	NO	NO	37
		NO	NO	NO	37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES		38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO		38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	YES		38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO		38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO		38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	YES	1-9005	40
40.01	NAME: HEALTHSOUTH CORPORATION	FI/CONTRACTOR'S NAME:	CAHABA GBA	FI/CONTRACTOR'S NUMBER: 10101
40.02	STREET: 3660 GRANDVIEW PARKWAY, SUITE 200	P.O. BOX:		40.02
40.03	CITY: BIRMINGHAM	STATE: AL	ZIP CODE: 35243	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES		41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO		43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO		44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO		45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.			46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
		1	2	3	4	5	
47	HOSPITAL	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?						52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.						52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						53
53.01	MDH PERIOD: BEGINNING: ENDING:						53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 28923 PAID LOSSES: 1848 AND/OR SELF INSURANCE:						54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.						54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.						55
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.						56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?						57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.						58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)						59

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO						60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)							60.01
MULTICAMPUS								
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	NO						61
	COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5			
SETTLEMENT DATA								
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)	YES	02/28/2009					63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS	
	TITLE	TITLE	TITLE			
	V 12	XVIII 13	XIX 14	15		
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		759	32	1071		1
2 HMO XIX						2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF						3
4 HOSPITAL ADULTS & PEDS - SWING BED NF						4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS						5
6 INTENSIVE CARE UNIT						6
7 CORONARY CARE UNIT						7
8 BURN INTENSIVE CARE UNIT						8
9 SURGICAL INTENSIVE CARE UNIT						9
10 OTHER SPECIAL CARE (SPECIFY)						10
11 NURSERY						11
12 TOTAL HOSPITAL		759	32	1071		12
13 RPCH VISITS						13
14 SUBPROVIDER I						14
15 SKILLED NURSING FACILITY						15
16 NURSING FACILITY						16
17 OTHER LONG TERM CARE						17
18 HOME HEALTH AGENCY						18
20 ASC (DISTINCT PART)						20
21 HOSPICE (DISTINCT PART)						21
23 O/P REHAB PROVIDER						23
24 RHC I						24
25 TOTAL						25
26 OBSERVATION BED DAYS						26
27 AMBULANCE TRIPS						27
28 EMPLOYEE DISCOUNT DAYS						28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
		1	2	3	4	5	6	
1	SALARIES							
1	TOTAL SALARIES	6514987			296795.20			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES		21513		707.20			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	93523			899.00		VENDOR INVOICES	9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES							9.03
10	CONTRACT LABOR: PHYSICIAN PART A	65250			474.00		VENDOR INVOICES	10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS	578525			8808.66		2008 HO REPORT	11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	1608359					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	5329					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)						CMS 339	19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS		71614		2080.00			21
22	ADMINISTRATIVE & GENERAL	1236230	-93127		40206.40			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT	1245			2.00			22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	136683			8257.60			24
25	LAUNDRY & LINEN SERVICE		23722		2080.00			25
26	HOUSEKEEPING	151995	-23722		11939.20			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	231888			18678.40			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	197008			8860.80			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	104491			6448.00			33
34	SOCIAL SERVICE	250832			9256.00			34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PART III

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	WORKSHEET S-3 PART III
		1	2	3	4	5	
1	NET SALARIES	6516232		6516232	296797.20	21.96	1
2	EXCLUDED AREA SALARIES		21513	21513	707.20	30.42	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	6516232	-21513	6494719	296090.00	21.93	3
4	SUBTOTAL OTHER WAGES & REL COSTS	737298		737298	10181.66	72.41	4
5	SUBTOTAL WAGE-RELATED COSTS	1608359		1608359		24.76%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	8861889	-21513	8840376	306271.66	28.86	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	2310372	-21513	2288859	107808.40	21.23	13

NHCOMQ DEMONSTRATION STATISTICAL DATA
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1		SERVICES ON OR AFTER JANUARY 1		TOTAL
		RATE	DAYS	RATE	DAYS	
1	2	3	3.01	4	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHB/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
14.01	RLX					14.01
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	DEFAULT RATE					45
46	TOTAL					46

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
GENERAL SERVICE COST CENTERS									
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		1221126	1221126	19111	1240237	79124	1319361	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		292853	292853	28562	321415	78571	399986	4
5	0500 EMPLOYEE BENEFITS		1241590	1241590	112445	1354035	347885	1701920	5
6	0600 ADMINISTRATIVE & GENERAL	1236230	2033875	3270105	-474429	2795676	504001	3299677	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	136683	274313	410996	302541	713537	-179443	534094	8
9	0900 LAUNDRY & LINEN SERVICE		6665	6665	22953	29618		29618	9
10	1000 HOUSEKEEPING	151995	35236	187231	-22582	164649		164649	10
11	1100 DIETARY	231888	236075	467963	9380	477343	-29942	447401	11
12	1200 CAFETERIA								12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	197008	28715	225723	-168	225555	-108	225447	14
15	1500 CENTRAL SERVICES & SUPPLY								15
16	1600 PHARMACY								16
17	1700 MEDICAL RECORDS & LIBRARY	104491	74061	178552		178552	-34	178518	17
18	1800 SOCIAL SERVICE	250832	3878	254710		254710	-284	254426	18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	2500 ADULTS & PEDIATRICS	2044406	186237	2230643	214	2230857	-1901	2228956	25
ANCILLARY SERVICE COST CENTERS									
41	4100 RADIOLOGY-DIAGNOSTIC		278305	278305		278305	-76577	201728	41
44	4400 LABORATORY		88662	88662		88662	-67166	21496	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	133395	27935	161330		161330	-10151	151179	49
50	5000 PHYSICAL THERAPY	774912	3236	778148	3372	781520	-311	781209	50
51	5100 OCCUPATIONAL THERAPY	637003	3763	640766	2267	643033	-465	642568	51
52	5200 SPEECH PATHOLOGY	316386	7636	324022	1832	325854	-65	325789	52
55	5500 MEDICAL SUPPLIES CHARGED TO PAT	41867	99048	140915	269	141184	-4213	136971	55
56	5600 DRUGS CHARGED TO PATIENTS	213357	487170	700527		700527	-3635	696892	56
59	59.01 3950 PSYCHIATRIC/PSYCHOLOGICAL SERVI	44534	54991	99525	-54000	45525	-165	45360	59
59.01	3950 AMBULANCE		50701	50701		50701	-36857	13844	59.01
59.02	3020 DAY TREATMENT		10886	10886	-10763	123	-123		59.02
OUTPATIENT SERVICE COST CENTERS									
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC								63.50
63.60	6320 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
88	8800 INTEREST EXPENSE		6939	6939		6939	-6939		88
90	9000 OTHER CAPITAL RELATED COSTS		21545	21545	-21545				90
95	SUBTOTALS	6514987	6775441	13290428	-80541	13209887	591202	13801089	95
NONREIMBURSABLE COST CENTERS									
98	9800 PHYSICIANS' PRIVATE OFFICES				684	684		684	98
100	7950 GUEST MEALS								100
100.01	7951 MARKETING				23337	23337		23337	100.01
100.03	7953 NON REIMBURSABLE PSYCH				56520	56520		56520	100.03
101	TOTAL	6514987	6775441	13290428		13290428	591202	13881630	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE		OTHER 5	
			LINE # 3	SALARY 4		
1						
2	B	MARKETING	100.01	21513	1824	1
3	C	ADULTS & PEDIATRICS	25		250	2
4	D	OPERATION OF PLANT	8		302912	3
5	G	DIETARY	11		9380	4
6	G					5
7	G					6
8	G					7
9	G					8
10	H	LAUNDRY & LINEN SERVICE	9			9
11	I	EMPLOYEE BENEFITS	5		529	10
12	J	NEW CAP REL COSTS-BLDG & FIXT	3	71614	40831	11
13	J	NEW CAP REL COSTS-MVBLE EQUIP	4		10474	12
14	K	PHYSICAL THERAPY	50		15654	13
15	K	OCCUPATIONAL THERAPY	51		4137	14
16	K	SPEECH PATHOLOGY	52		2274	15
17	L	PHYSICIANS' PRIVATE OFFICES	98		1832	16
18	M	MEDICAL SUPPLIES CHARGED TO P	55		684	17
19	O	LAUNDRY & LINEN SERVICE	9	23722	269	18
20	P	PSYCHIATRIC/PSYCHOLOGICAL SER	59			19
21	P	NON REIMBURSABLE PSYCH	100.03		2520	20
22	R	HOUSEKEEPING	10		56520	21
23	R				1669	22
24						23
25						24
26						25
27						26
28						27
29						28
30						29
31						30
32						31
33						32
34						33
35						34
36		TOTAL RECLASSIFICATIONS		116849	451759	35
						36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
1	1	6	7	8	9	10
1 TO RECLASS MARKETING EXPENSES	B	ADMINISTRATIVE & GENERAL	6	21513	1824	1
2 RECLASS MEDICAL DIR FEES	C	ADMINISTRATIVE & GENERAL	6		250	2
3 TO RECLASS MEDICAL DIRECTOR FEES	C					3
4 TO RECLASS UTILITY EXPENSES	D	ADMINISTRATIVE & GENERAL	6		302912	4
5 FOOD SUPPLIES	G	ADMINISTRATIVE & GENERAL	6		8673	5
6 FOOD SUPPLIES	G	ADULTS & PEDIATRICS	25		36	6
7 FOOD SUPPLIES	G	PHYSICAL THERAPY	50		496	7
8 FOOD SUPPLIES	G	OCCUPATIONAL THERAPY	51		7	8
9 FOOD SUPPLIES	G	NURSING ADMINISTRATION	14		168	9
10 LINENS RECLASS	H	HOUSEKEEPING	10		529	10
11 HUMAN RESOURCES	I	ADMINISTRATIVE & GENERAL	6	71614	40831	11
12 CAPITAL INSURANCE	J	ADMINISTRATIVE & GENERAL	6		26128	12
13 CAPITAL INSURANCE	J					12
14 DAY TREATMENT	K	DAY TREATMENT	59.02		8243	14
15 DAY TREATMENT	K					15
16 DAY TREATMENT	K					16
17 PHYSICIAN SUPPLIES RECLASS	L	ADMINISTRATIVE & GENERAL	6		684	17
18 COMS RECLASS	M	PHYSICAL THERAPY	50		269	18
19 LAUNDRY	O	HOUSEKEEPING	10	23722		19
20 PSYCH RECLASS	P	DAY TREATMENT	59.02		2520	20
21 PSYCH RECLASS	P	PSYCHIATRIC/PSYCHOLOGICAL SER	59		56520	21
22 HOUSEKEEPING	R	LAUNDRY & LINEN SERVICE	9		1298	22
23 HOUSEKEEPING	R	OPERATION OF PLANT	8		371	23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				116849	451759	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES	1391529	43958		43958		1435487		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	2036678	358034		358034	249180	2145532		6
7 SUBTOTAL	3428207	401992		401992	249180	3581019		7
8 RECONCILING ITEMS								8
9 TOTAL	3428207	401992		401992	249180	3581019		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL				TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	1435487		1435487	.400860		8637		8637 3
4 NEW CAP REL COSTS-MVBLE EQUIP	2145532		2145532	.599140		12908		12908 4
5 TOTAL	3581019		3581019	1.000000		21545		21545 5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS		
	9	10	11	12	13	14	15	
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT	273117	886324	77146	10474	72300			1319361 3
4 NEW CAP REL COSTS-MVBLE EQUIP	179813	96459		15654	108060			399986 4
5 TOTAL	452930	982783	77146	26128	180360			1719347 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS		
	9	10	11	12	13	14	15	
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT	152186	1068940						1221126 3
4 NEW CAP REL COSTS-MVBLE EQUIP	191128	101725						292853 4
5 TOTAL	343314	1170665						1513979 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKST A-7	
			COST CENTER	LINE NO.	WKST A-7	REF
	1	2	3	4	5	
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5 INVESTMENT INCOME-OTHER						5
6 TRADE, QUANTITY, AND TIME DISCOUNTS						6
7 REFUNDS AND REBATES OF EXPENSES						7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS						8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10 TELEVISION AND RADIO SERVICE						10
11 PARKING LOT						11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST					
	A-8-2	-3				12
13 SALE OF SCRAP, WASTE, ETC.						13
14 RELATED ORGANIZATION TRANSACTIONS	WKST					
	A-8-1	705235				14
15 LAUNDRY AND LINEN SERVICE						15
16 CAFETERIA - EMPLOYEES AND GUESTS						16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19 SALE OF DRUGS TO OTHER THAN PATIENTS						19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS						20
21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						21
22 VENDING MACHINES						22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49		25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50		26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST					
	A-8-3		HOME HEALTH AGENCY	71		27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES	A		NEW CAP REL COSTS-BLDG & FIXT	3	9	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT	A		NEW CAP REL COSTS-MVBLE EQUIP	4	9	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34 PHYSICIANS' ASSISTANT						34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST					
	WKST A-8-4					35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST					
	WKST A-8-4					
37 LINE OF CREDIT INTEREST	A	-7121	INTEREST EXPENSE	88		36
38 PROPERTY TAX	A	63663	NEW CAP REL COSTS-BLDG & FIXT	3	13	37
38.01 PROPERTY TAX	A	95152	NEW CAP REL COSTS-MVBLE EQUIP	4	13	38
39 NON-ALLOWABLE EXPENSES	A	-97371	ADMINISTRATIVE & GENERAL	6		38.01
40 PATIENT PHONE	A	-24830	ADMINISTRATIVE & GENERAL	6		39
40.01 PATIENT PHONE	A	-6150	EMPLOYEE BENEFITS	5		40
40.02 PATIENT PHONE	A	-3015	NEW CAP REL COSTS-MVBLE EQUIP	4	9	40.01
40.04 PATIENT PHONE	A	-7797	ADMINISTRATIVE & GENERAL	6		40.02
41 TV DEPRECIATION	A	-240	NEW CAP REL COSTS-MVBLE EQUIP	4	9	40.04
41.02 PATIENT TV	A	-561	ADMINISTRATIVE & GENERAL	6		41
42 TO OFFSET MISCELLANEOUS INCOME	B	-6688	NEW CAP REL COSTS-BLDG & FIXT	3	11	41.02
42.01 MISC INCOME	B	-22	ADMINISTRATIVE & GENERAL	6		42
42.02 MISC INCOME	B	-29883	DIETARY	11		42.01
42.03 MISC INCOME	B	-34	MEDICAL RECORDS & LIBRARY	17		42.02
42.04 MISC INCOME	B	-609	DRUGS CHARGED TO PATIENTS	56		42.03
43 PATIENT TRANSPORTATION	A	-96562	OPERATION OF PLANT	8		42.04
43.01 PATIENT TRANSPORTATION	A	-16038	EMPLOYEE BENEFITS	5		43
43.02 PATIENT TRANSPORTATION	A	-36857	AMBULANCE	59.01		43.01
43.03 PATIENT TRANSPORTATION	A	48	ADMINISTRATIVE & GENERAL	6		43.02
43.04 PATIENT TRANSPORTATION	A	-24125	OPERATION OF PLANT	8		43.03
43.05 VAN DEPRECIATION	A	-8052	NEW CAP REL COSTS-MVBLE EQUIP	4	9	43.04
44 OFFSET PROPERTY TAX ACCRUED TO	A	-182616	NEW CAP REL COSTS-BLDG & FIXT	3	10	43.05
45 IN WORKFORCE DEVELOPMENT TAX	A	-1419	ADMINISTRATIVE & GENERAL	6		44
46						45
47 PROFESSIONAL FEES	A	-60375	ADMINISTRATIVE & GENERAL	6		46
48 MD FEE ACCRUALS	A	5810	ADMINISTRATIVE & GENERAL	6		47
49 TO OFFSET PRINT SHOP COSTS	A	-5415	ADMINISTRATIVE & GENERAL	6		48
49.01 TO OFFSET PRINT SHOP COSTS	A	-30	OPERATION OF PLANT	8		49
49.02 TO OFFSET PRINT SHOP COSTS	A	-59	DIETARY	11		49.01
49.03 TO OFFSET PRINT SHOP COSTS	A	-24	NURSING ADMINISTRATION	14		49.02

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
49.04 TO OFFSET PRINT SHOP COSTS	A	-284	SOCIAL SERVICE	18	49.04
49.05 TO OFFSET PRINT SHOP COSTS	A	-1880	ADULTS & PEDIATRICS	25	49.05
49.06 TO OFFSET PRINT SHOP COSTS	A	-28	RESPIRATORY THERAPY	49	49.06
49.07 TO OFFSET PRINT SHOP COSTS	A	-228	PHYSICAL THERAPY	50	49.07
49.08 TO OFFSET PRINT SHOP COSTS	A	-13	OCCUPATIONAL THERAPY	51	49.08
49.09 TO OFFSET PRINT SHOP COSTS	A	-65	SPEECH PATHOLOGY	52	49.09
49.10 TO OFFSET PRINT SHOP COSTS	A	-42	DRUGS CHARGED TO PATIENTS	56	49.10
49.11 TO OFFSET PRINT SHOP COSTS	A	-106	DAY TREATMENT	59.02	49.11
49.19 MEDICAL & DENTAL INSURANCE	A	385302	EMPLOYEE BENEFITS	5	49.19
49.20 WORKERS COMP INSURANCE	A	-29858	ADMINISTRATIVE & GENERAL	6	49.20
49.21 GENERAL LIABILITY INSURANCE	A	-13204	EMPLOYEE BENEFITS	5	49.21
49.22 PHYSICIAN SUPPLIES ADJUSTMENT	A	668	ADMINISTRATIVE & GENERAL	6	49.22
49.23 LOBBYING	A	-205	ADMINISTRATIVE & GENERAL	6	49.23
49.24 LOBBYING	A	-51	EMPLOYEE BENEFITS	5	49.24
49.25 LOBBYING	A	-2816	ADMINISTRATIVE & GENERAL	6	49.25
50 TOTAL		591202			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1	6	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES		997921	
2	3	NEW CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	120931		120931
3	3	NEW CAP REL COSTS-BLDG & FIXT	HOME OFFICE INTEREST	83834		83834
4	6	ADMINISTRATIVE & GENERAL	HOME OFFICE A&G	1028062		1028062
4.01	6	ADMINISTRATIVE & GENERAL	HOME OFFICE OPERATING A&G	707278		707278
4.02	88	INTEREST EXPENSE	IC INTEREST		-182	182
4.04	3	NEW CAP REL COSTS-BLDG & FIXT	IC WAGE/EXPENSE TRANSFER	98411	98411	
4.05	4	NEW CAP REL COSTS-MVBLE EQUIP	IC WAGE/EXPENSE TRANSFER	-1769	-1769	
4.06	5	EMPLOYEE BENEFITS	IC WAGE/EXPENSE TRANSFER	788514	788514	
4.07	6	ADMINISTRATIVE & GENERAL	IC WAGE/EXPENSE TRANSFER	759936	759936	
4.08	8	OPERATION OF PLANT	IC WAGE/EXPENSE TRANSFER	-21477	-21477	
4.09	10	HOUSEKEEPING	IC WAGE/EXPENSE TRANSFER	-8244	-8244	
4.10	11	DIETARY	IC WAGE/EXPENSE TRANSFER	-16826	-16826	
4.11	14	NURSING ADMINISTRATION	IC WAGE/EXPENSE TRANSFER	-5834	-5834	
4.12	17	MEDICAL RECORDS & LIBRARY	IC WAGE/EXPENSE TRANSFER	-4688	-4688	
4.13	18	SOCIAL SERVICE	IC WAGE/EXPENSE TRANSFER	-10564	-10564	
4.14	25	ADULTS & PEDIATRICS	IC WAGE/EXPENSE TRANSFER	-86480	-86480	
4.15	41	RADIOLOGY-DIAGNOSTIC	IC WAGE/EXPENSE TRANSFER	-31394	-31394	
4.16	44	LABORATORY	IC WAGE/EXPENSE TRANSFER	5600	5600	
4.17	49	RESPIRATORY THERAPY	IC WAGE/EXPENSE TRANSFER	-4387	-4387	
4.18	50	PHYSICAL THERAPY	IC WAGE/EXPENSE TRANSFER	-44906	-44906	
4.19	51	OCCUPATIONAL THERAPY	IC WAGE/EXPENSE TRANSFER	-27202	-27202	
4.20	52	SPEECH PATHOLOGY	IC WAGE/EXPENSE TRANSFER	-12955	-12955	
4.21	55	MEDICAL SUPPLIES CHARGED TO PAT	IC WAGE/EXPENSE TRANSFER	-3310	-3310	
4.22	56	DRUGS CHARGED TO PATIENTS	IC WAGE/EXPENSE TRANSFER	403462	403462	
4.23	59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	IC WAGE/EXPENSE TRANSFER	229	229	
4.24	59.01	AMBULANCE	IC WAGE/EXPENSE TRANSFER	-5521	-5521	
4.25	59.02	DAY TREATMENT	IC WAGE/EXPENSE TRANSFER	-124	-124	
4.26	4	NEW CAP REL COSTS-MVBLE EQUIP	RELATED PARTY DEACONESS	2312	7578	-5266
4.27	5	EMPLOYEE BENEFITS	RELATED PARTY DEACONESS	867	2841	-1974
4.28	6	ADMINISTRATIVE & GENERAL	RELATED PARTY DEACONESS	2755	9030	-6275
4.29	6	ADMINISTRATIVE & GENERAL	RELATED PARTY DEACONESS		3000	-3000
4.30	8	OPERATION OF PLANT	RELATED PARTY DEACONESS	25789	84515	-58726
4.31	14	NURSING ADMINISTRATION	RELATED PARTY DEACONESS	37	121	-84
4.32	25	ADULTS & PEDIATRICS	RELATED PARTY DEACONESS	54	72	-18
4.33	41	RADIOLOGY-DIAGNOSTIC	RELATED PARTY DEACONESS	20322	80470	-60148
4.34	44	LABORATORY	RELATED PARTY DEACONESS	21496	88662	-67166
4.35	49	RESPIRATORY THERAPY	RELATED PARTY DEACONESS	3772	13895	-10123
4.36	50	PHYSICAL THERAPY	RELATED PARTY DEACONESS	29	112	-83
4.37	51	OCCUPATIONAL THERAPY	RELATED PARTY DEACONESS	199	651	-452
4.38	55	MEDICAL SUPPLIES CHARGED TO PAT	RELATED PARTY DEACONESS	3505	7718	-4213
4.39	56	DRUGS CHARGED TO PATIENTS	RELATED PARTY DEACONESS	767	3751	-2984
4.40	59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	RELATED PARTY DEACONESS	315	480	-165
4.41	59.02	DAY TREATMENT	RELATED PARTY DEACONESS	8	25	-17
4.42	41	RADIOLOGY-DIAGNOSTIC	RELATED PARTY MIDWEST	10609	27038	-16429
4.43	6	ADMINISTRATIVE & GENERAL	RELATED PARTY MOTORIKA	2052	2052	
4.44	4	NEW CAP REL COSTS-MVBLE EQUIP	MCD DEPRECIATION	164	172	-8
5		TOTALS		3805628	3100393	705235

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP		NAME	PERCENT OF OWNERSHIP		TYPE OF BUSINESS	
		3	4		5	6		
1	B	78.00	HEALTHSOUTH COR			HEALTHCARE		1
2	B	22.00	DEACONESS			HEALTHCARE		2
3	G		HEALTHSOUTH COR			HEALTHCARE		3
4	G		MEDCENTERDIRECT			MEDICAL SUPPLIES		4
5	G		MIDWEST RADIOLOGICAL			RADIOLOGY SERVICES		5
5.01	G		MOTORIKA			EQUIPMENT		5.01

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY: MEDICAL SUPPLIES VENDOR

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.01
 05/15/2009 14:43

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	25 ADULTS & PEDIATRICS	250		250	171400	3	247	12
101	TOTAL	250		250		3	247	12

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.01
 05/15/2009 14:43

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUST- MENT 18
1	25	ADULTS & PEDIATRICS		AGGREGATE			247	3	3
101		TOTAL					247	3	3

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINISTRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	1319361	1319361							3
4 NEW CAP REL COSTS-MVBLE EQUIP	399986		399986						4
5 EMPLOYEE BENEFITS	1701920	4333	1447	1707700					5
6 ADMINISTRATIVE & GENERAL	3299677	129485	43229	302959	3775350	3775350			6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	534094	26216	8752	36225	605287	226114	831401		8
9 LAUNDRY & LINEN SERVICE	29618	14685	4903	6287	55493	20730	10531	86754	9
10 HOUSEKEEPING	164649	10679	3565	33996	212889	79528	7658	2623	10
11 DIETARY	447401	93732	31293	61458	633884	236797	67219	901	11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	225447	11096	3704	52213	292460	109253	7957		14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY	178518	9972	3329	27693	219512	82002	7151		17
18 SOCIAL SERVICE	254426	7923	2645	66479	331473	123827	5682		18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	2228956	544445	181766	541835	3497002	1306356	390446	70650	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	201728	11676	3898		217302	81176	8373	25	41
44 LABORATORY	21496	979	327		22802	8518	702		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	151179	2792	932	35354	190257	71073	2002		49
50 PHYSICAL THERAPY	781209	170060	56775	205376	1213420	453291	121957	7710	50
51 OCCUPATIONAL THERAPY	642568	86662	28932	168826	926988	346290	62149	1299	51
52 SPEECH PATHOLOGY	325789	37837	12632	83852	460110	171881	27135	11	52
55 MEDICAL SUPPLIES CHARGED TO PAT	136971	22663	7566	11096	178296	66605	16252		55
56 DRUGS CHARGED TO PATIENTS	696892	7252	2421	56546	763111	285072	5201		56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	45360	4895	1634	11803	63692	23793	3510		59
59.01 AMBULANCE	13844				13844	5172			59.01
59.02 DAY TREATMENT									59.02
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	13801089	1197382	399750	1701998	13673172	3697478	743925	83219	95
NONREIMBURSABLE COST CENTERS									
98 PHYSICIANS' PRIVATE OFFICES	684	121272			121956	45558	86969	3535	98
100 GUEST MEALS									100
100.01MARKETING	23337	381	127	5702	29547	11038	273		100.01
100.03NON REIMBURSABLE PSYCH	56520	326	109		56955	21276	234		100.03
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	13881630	1319361	399986	1707700	13881630	3775350	831401	86754	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS
	10	11	12	14	17	18	25	26
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	302698							10
11 DIETARY	28017	966818						11
12 CAFETERIA		261677	261677					12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	3317		10859	423846				14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY	2981		7902		319548			17
18 SOCIAL SERVICE	2368		11343			474693		18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	162734	629814	131730	423846	100712	474693	7187983	25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	3490				4970		315336	41
44 LABORATORY	293				4971		37286	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY	835		7468		11441		283076	49
50 PHYSICAL THERAPY	50832		39840		67724		1954774	50
51 OCCUPATIONAL THERAPY	25904		26178		60021		1448829	51
52 SPEECH PATHOLOGY	11310		13790		28430		712667	52
55 MEDICAL SUPPLIES CHARGED TO PAT	6774		3008		5140		276075	55
56 DRUGS CHARGED TO PATIENTS	2168		6143		31541		1093236	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	1463		2549		3742		98749	59
59.01 AMBULANCE					605		19621	59.01
59.02 DAY TREATMENT								59.02
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	302486	891491	260810	423846	319297	474693	13427632	95
NONREIMBURSABLE COST CENTERS								
98 PHYSICIANS' PRIVATE OFFICES							258018	98
100 GUEST MEALS		75327					75327	100
100.01MARKETING	114		867				41839	100.01
100.03NON REIMBURSABLE PSYCH	98				251		78814	100.03
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	302698	966818	261677	423846	319548	474693	13881630	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		27	
GENERAL SERVICE COST CENTERS			
1	OLD CAP REL COSTS-BLDG & FIXT		1
2	OLD CAP REL COSTS-MVBLE EQUIP		2
3	NEW CAP REL COSTS-BLDG & FIXT		3
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
7	MAINTENANCE & REPAIRS		7
8	OPERATION OF PLANT		8
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
13	MAINTENANCE OF PERSONNEL		13
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY		17
18	SOCIAL SERVICE		18
20	NONPHYSICIAN ANESTHETISTS		20
21	NURSING SCHOOL		21
22	I&R SERVICES-SALARY & FRINGES A		22
23	I&R SERVICES-OTHER PRGM COSTS A		23
24	PARAMED ED PRGM-(SPECIFY)		24
INPATIENT ROUTINE SERV COST CENTERS			
25	ADULTS & PEDIATRICS	7187983	25
ANCILLARY SERVICE COST CENTERS			
41	RADIOLOGY-DIAGNOSTIC	315336	41
44	LABORATORY	37286	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO		46.30
49	RESPIRATORY THERAPY	283076	49
50	PHYSICAL THERAPY	1954774	50
51	OCCUPATIONAL THERAPY	1448829	51
52	SPEECH PATHOLOGY	712667	52
55	MEDICAL SUPPLIES CHARGED TO PAT	276075	55
56	DRUGS CHARGED TO PATIENTS	1093236	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	98749	59
59.01	AMBULANCE	19621	59.01
59.02	DAY TREATMENT		59.02
OUTPATIENT SERVICE COST CENTERS			
62	OBSERVATION BEDS (NON-DISTINCT		62
63.50	RHC		63.50
63.60	FQHC		63.60
OTHER REIMBURSABLE COST CENTERS			
69.10	CMHC		69.10
69.20	OUTPATIENT PHYSICAL THERAPY		69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY		69.30
69.40	OUTPATIENT SPEECH PATHOLOGY		69.40
71	HOME HEALTH AGENCY		71
SPECIAL PURPOSE COST CENTERS			
85.01	PANCREAS ACQUISITION		85.01
85.02	INTESTINAL ACQUISITION		85.02
85.03	ISLET CELL ACQUISITION		85.03
95	SUBTOTALS	13427632	95
NONREIMBURSABLE COST CENTERS			
98	PHYSICIANS' PRIVATE OFFICES	258018	98
100	GUEST MEALS	75327	100
100.01	MARKETING	41839	100.01
100.03	NON REIMBURSABLE PSYCH	78814	100.03
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	TOTAL	13881630	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS		4333	1447	5780	5780				5
6 ADMINISTRATIVE & GENERAL	129485		43229	172714	1025	173739			6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT		26216	8752	34968	123	10405	45496		8
9 LAUNDRY & LINEN SERVICE		14685	4903	19588	21	954	576	21139	9
10 HOUSEKEEPING		10679	3565	14244	115	3660	419	639	10
11 DIETARY		93732	31293	125025	208	10897	3678	219	11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	11096		3704	14800	177	5028	435		14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY	9972		3329	13301	94	3774	391		17
18 SOCIAL SERVICE	7923		2645	10568	225	5698	311		18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
25 INPATIENT ROUTINE SERV COST CENTERS									
ADULTS & PEDIATRICS	544445	181766	726211	1834	60117	21367	17215	25	
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	11676	3898	15574		3736	458	6	41	
44 LABORATORY	979	327	1306		392	38		44	
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	2792	932	3724	120	3271	110		49	
50 PHYSICAL THERAPY	170060	56775	226835	695	20860	6674	1879	50	
51 OCCUPATIONAL THERAPY	86662	28932	115594	571	15936	3401	317	51	
52 SPEECH PATHOLOGY	37837	12632	50469	284	7910	1485	3	52	
55 MEDICAL SUPPLIES CHARGED TO PAT	22663	7566	30229	38	3065	889		55	
56 DRUGS CHARGED TO PATIENTS	7252	2421	9673	191	13119	285		56	
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	4895	1634	6529	40	1095	192		59	
59.01 AMBULANCE					238			59.01	
59.02 DAY TREATMENT								59.02	
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINCT								62	
63.50 RHC								63.50	
63.60 FQHC								63.60	
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC								69.10	
69.20 OUTPATIENT PHYSICAL THERAPY								69.20	
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30	
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40	
71 HOME HEALTH AGENCY								71	
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION								85.01	
85.02 INTESTINAL ACQUISITION								85.02	
85.03 ISLET CELL ACQUISITION								85.03	
95 SUBTOTALS	1197382	399750	1597132	5761	170155	40709	20278	95	
NONREIMBURSABLE COST CENTERS									
98 PHYSICIANS' PRIVATE OFFICES	121272		121272		2097	4759	861	98	
100 GUEST MEALS								100	
100.01MARKETING	381	127	508	19	508	15		100.01	
100.03NON REIMBURSABLE PSYCH	326	109	435		979	13		100.03	
101 CROSS FOOT ADJUSTMENTS								101	
102 NEGATIVE COST CENTER								102	
103 TOTAL	1319361	399986	1719347	5780	173739	45496	21139	103	

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS
	10	11	12	14	17	18		25
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	19077							10
11 DIETARY	1766	141793						11
12 CAFETERIA		38377	38377					12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	209		1592	22241				14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY	188		1159		18907			17
18 SOCIAL SERVICE	149		1664			18615		18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	10255	92369	19320	22241	5964	18615	995508	25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	220				294		20288	41
44 LABORATORY	18				294		2048	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY	53		1095		677		9050	49
50 PHYSICAL THERAPY	3204		5843		4006		269996	50
51 OCCUPATIONAL THERAPY	1633		3839		3550		144841	51
52 SPEECH PATHOLOGY	713		2022		1681		64567	52
55 MEDICAL SUPPLIES CHARGED TO PAT	427		441		304		35393	55
56 DRUGS CHARGED TO PATIENTS	137		901		1865		26171	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	92		374		221		8543	59
59.01 AMBULANCE					36		274	59.01
59.02 DAY TREATMENT								59.02
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	19064	130746	38250	22241	18892	18615	1576679	95
NONREIMBURSABLE COST CENTERS								
98 PHYSICIANS' PRIVATE OFFICES							128989	98
100 GUEST MEALS		11047					11047	100
100.01MARKETING	7		127				1184	100.01
100.03NON REIMBURSABLE PSYCH	6				15		1448	100.03
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	19077	141793	38377	22241	18907	18615	1719347	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION		TOTAL	
		27	
GENERAL SERVICE COST CENTERS			
1	OLD CAP REL COSTS-BLDG & FIXT		1
2	OLD CAP REL COSTS-MVBLE EQUIP		2
3	NEW CAP REL COSTS-BLDG & FIXT		3
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
7	MAINTENANCE & REPAIRS		7
8	OPERATION OF PLANT		8
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
13	MAINTENANCE OF PERSONNEL		13
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY		17
18	SOCIAL SERVICE		18
20	NONPHYSICIAN ANESTHETISTS		20
21	NURSING SCHOOL		21
22	I&R SERVICES-SALARY & FRINGES A		22
23	I&R SERVICES-OTHER PRGM COSTS A		23
24	PARAMED ED PRGM-(SPECIFY)		24
INPATIENT ROUTINE SERV COST CENTERS			
25	ADULTS & PEDIATRICS	995508	25
ANCILLARY SERVICE COST CENTERS			
41	RADIOLOGY-DIAGNOSTIC	20288	41
44	LABORATORY	2048	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO		46.30
49	RESPIRATORY THERAPY	9050	49
50	PHYSICAL THERAPY	269996	50
51	OCCUPATIONAL THERAPY	144841	51
52	SPEECH PATHOLOGY	64567	52
55	MEDICAL SUPPLIES CHARGED TO PAT	35393	55
56	DRUGS CHARGED TO PATIENTS	26171	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	8543	59
59.01	AMBULANCE	274	59.01
59.02	DAY TREATMENT		59.02
OUTPATIENT SERVICE COST CENTERS			
62	OBSERVATION BEDS (NON-DISTINCT		62
63.50	RHC		63.50
63.60	FQHC		63.60
OTHER REIMBURSABLE COST CENTERS			
69.10	CMHC		69.10
69.20	OUTPATIENT PHYSICAL THERAPY		69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY		69.30
69.40	OUTPATIENT SPEECH PATHOLOGY		69.40
71	HOME HEALTH AGENCY		71
SPECIAL PURPOSE COST CENTERS			
85.01	PANCREAS ACQUISITION		85.01
85.02	INTESTINAL ACQUISITION		85.02
85.03	ISLET CELL ACQUISITION		85.03
95	SUBTOTALS	1576679	95
NONREIMBURSABLE COST CENTERS			
98	PHYSICIANS' PRIVATE OFFICES	128989	98
100	GUEST MEALS	11047	100
100.01	MARKETING	1184	100.01
100.03	NON REIMBURSABLE PSYCH	1448	100.03
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	TOTAL	1719347	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		3	4	5	6A	6	8	9	
GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	72772							3
4	NEW CAP REL COSTS-MVBLE EQUIP		66083						4
5	EMPLOYEE BENEFITS	239	239	6443373					5
6	ADMINISTRATIVE & GENERAL	7142	7142	1143103	-3775350	10106280			6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT	1446	1446	136683		605287	63945		8
9	LAUNDRY & LINEN SERVICE	810	810	23722		55493	810	158134	9
10	HOUSEKEEPING	589	589	128273		212889	589	4782	10
11	DIETARY	5170	5170	231888		633884	5170	1642	11
12	CAFETERIA								12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION	612	612	197008		292460	612		14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY	550	550	104491		219512	550		17
18	SOCIAL SERVICE	437	437	250832		331473	437		18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	30030	30030	2044406		3497002	30030	128780	25
ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC	644	644			217302	644	45	41
44	LABORATORY	54	54			22802	54		44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY	154	154	133395		190257	154		49
50	PHYSICAL THERAPY	9380	9380	774912		1213420	9380	14053	50
51	OCCUPATIONAL THERAPY	4780	4780	637003		926988	4780	2368	51
52	SPEECH PATHOLOGY	2087	2087	316386		460110	2087	20	52
55	MEDICAL SUPPLIES CHARGED TO P	1250	1250	41867		178296	1250		55
56	DRUGS CHARGED TO PATIENTS	400	400	213357		763111	400		56
59	PSYCHIATRIC/PSYCHOLOGICAL SER	270	270	44534		63692	270		59
59.01	AMBULANCE					13844			59.01
59.02	DAY TREATMENT								59.02
OUTPATIENT SERVICE COST CENTERS									
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC								63.50
63.60	FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	66044	66044	6421860	-3775350	9897822	57217	151690	95
NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	6689				121956	6689	6444	98
100	GUEST MEALS								100
100.01	MARKETING	21	21	21513		29547	21		100.01
100.03	NON REIMBURSABLE PSYCH	18	18			56955	18		100.03
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	1319361	399986	1707700		3775350	831401	86754	103
104	UNIT COST MULT-WS B PT I		6.052782				13.001814		104
104	UNIT COST MULT-WS B PT I	18.130064		.265032		.373565		.548611	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III			5780		173739	45496	21139	107
108	UNIT COST MULT-WS B PT III						.711486		108
108	UNIT COST MULT-WS B PT III			.000897		.017191		.133678	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	SQUARE FEET	MEALS SERVED	FTE'S	PATIENT DAYS	GROSS REVENUE	PATIENT DAYS	
	10	11	12	14	17	18	
GENERAL SERVICE COST CENTERS							
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	HOUSEKEEPING	55857					10
11	DIETARY	5170					11
12	CAFETERIA		19735	10266			12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION	612		426	15833		14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY	550		310	34236769		17
18	SOCIAL SERVICE	437		445		15833	18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES						22
23	I&R SERVICES-OTHER PRGM COSTS						23
24	PARAMED ED PRGM-(SPECIFY)						24
25	INPATIENT ROUTINE SERV COST CENTERS						
	ADULTS & PEDIATRICS	30030	47499	5168	15833	10789115	15833
							25
ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	644			532469		41
44	LABORATORY	54			532588		44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY	154		293	1225909		49
50	PHYSICAL THERAPY	9380		1563	7256454		50
51	OCCUPATIONAL THERAPY	4780		1027	6431097		51
52	SPEECH PATHOLOGY	2087		541	3046185		52
55	MEDICAL SUPPLIES CHARGED TO P	1250		118	550754		55
56	DRUGS CHARGED TO PATIENTS	400		241	3379484		56
59	PSYCHIATRIC/PSYCHOLOGICAL SER	270		100	400954		59
59.01	AMBULANCE				64841		59.01
59.02	DAY TREATMENT						59.02
OUTPATIENT SERVICE COST CENTERS							
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.60	FQHC						63.60
OTHER REIMBURSABLE COST CENTERS							
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERA						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
95	SUBTOTALS	55818	67234	10232	15833	34209850	15833
95	NONREIMBURSABLE COST CENTERS						95
98	PHYSICIANS' PRIVATE OFFICES						98
100	GUEST MEALS		5681				100
100.01	MARKETING	21		34			100.01
100.03	NON REIMBURSABLE PSYCH	18			26919		100.03
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	COST TO BE ALLOC PER B PT I	302698	966818	261677	423846	319548	474693
104	UNIT COST MULT-WS B PT I	5.419160		25.489675		.009333	
104	UNIT COST MULT-WS B PT I		13.259521		26.769785		29.981242
105	COST TO BE ALLOC PER B PT II						
106	UNIT COST MULT-WS B PT II						
106	UNIT COST MULT-WS B PT II						
107	COST TO BE ALLOC PER B PT III	19077	141793	38377	22241	18907	18615
108	UNIT COST MULT-WS B PT III	.341533		3.738262		.000552	
108	UNIT COST MULT-WS B PT III		1.944634		1.404724		1.175709

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	7187983		7187983	3	7187986	25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	315336		315336		315336	41
44 LABORATORY	37286		37286		37286	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	283076		283076		283076	49
50 PHYSICAL THERAPY	1954774		1954774		1954774	50
51 OCCUPATIONAL THERAPY	1448829		1448829		1448829	51
52 SPEECH PATHOLOGY	712667		712667		712667	52
55 MEDICAL SUPPLIES CHARGED TO	276075		276075		276075	55
56 DRUGS CHARGED TO PATIENTS	1093236		1093236		1093236	56
59 PSYCHIATRIC/PSYCHOLOGICAL S	98749		98749		98749	59
59.01 AMBULANCE	19621		19621		19621	59.01
59.02 DAY TREATMENT						59.02
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	13427632		13427632	3	13427635	101
102 LESS OBSERVATION BEDS						102
103 TOTAL	13427632		13427632	3	13427635	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	10789115		10789115			25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	528958	3511	532469	.592215	.592215	.592215 41
44 LABORATORY	528653	3935	532588	.070009	.070009	.070009 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	1225859	50	1225909	.230911	.230911	.230911 49
50 PHYSICAL THERAPY	5798061	1458393	7256454	.269384	.269384	.269384 50
51 OCCUPATIONAL THERAPY	5629611	801486	6431097	.225285	.225285	.225285 51
52 SPEECH PATHOLOGY	2400488	645697	3046185	.233954	.233954	.233954 52
55 MEDICAL SUPPLIES CHARGED TO	543523	7231	550754	.501267	.501267	.501267 55
56 DRUGS CHARGED TO PATIENTS	3332855	46629	3379484	.323492	.323492	.323492 56
59 PSYCHIATRIC/PSYCHOLOGICAL S	399366	1588	400954	.246285	.246285	.246285 59
59.01 AMBULANCE	64841		64841	.302602	.302602	.302602 59.01
59.02 DAY TREATMENT						59.02
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	31241330	2968520	34209850			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	31241330	2968520	34209850			103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	CAPITAL RELATED COST 1	SWING-BED ADJUSTMENT 2	REDUCED CAPITAL RELATED COST 3	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	REDUCED CAPITAL RELATED COST 6
25 INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				995508		995508
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				995508		995508

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	PER DIEM 11	INPATIENT PROGRAM CAPITAL COST 12
25 INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	15833	11168			62.88	702244
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	15833	11168				702244

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK TITLE V HOSPITAL (15-3025) SUB III PPS
 APPLICABLE TITLE XVIII-PT A SUB I SUB IV TEFRA
 BOXES TITLE XIX SUB II

COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	OLD CAPITAL		NEW CAPITAL		
	RELATED COST	RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS	
	1	2	3	4	5	6	7	8	
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC		20288	532469	361757			.038102	13784	41
44 LABORATORY		2048	532588	401662			.003845	1544	44
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
49 RESPIRATORY THERAPY		9050	1225909	974789			.007382	7196	49
50 PHYSICAL THERAPY		269996	7256454	4042002			.037208	150395	50
51 OCCUPATIONAL THERAPY		144841	6431097	3903024			.022522	87904	51
52 SPEECH PATHOLOGY		64567	3046185	1577412			.021196	33435	52
55 MEDICAL SUPPLIES CHARGED TO P		35393	550754	300811			.064263	19331	55
56 DRUGS CHARGED TO PATIENTS		26171	3379484	2465050			.007744	19089	56
59 PSYCHIATRIC/PSYCHOLOGICAL SER		8543	400954	265952			.021307	5667	59
59.01 AMBULANCE		274	64841	31497			.004226	133	59.01
59.02 DAY TREATMENT									59.02
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINC									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		581171	23420735	14323956				338478	101

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

	COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT		PATIENT		PROGRAM	PROGRAM
		COST	COST	AMOUNT	COSTS	DAYS	DIEM	DAYS	PASS THRU
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					15833		11168	25
26	INTENSIVE CARE UNIT								26
27	CORONARY CARE UNIT								27
28	BURN INTENSIVE CARE UNIT								28
29	SURGICAL INTENSIVE CARE UNIT								29
30	OTHER SPECIAL CARE (SPECIFY)								30
31	SUBPROVIDER I								31
33	NURSERY								33
34	SKILLED NURSING FACILITY								34
35	NURSING FACILITY								35
101	TOTAL					15833		11168	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-3025) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
59 PSYCHIATRIC/PSYCHOLOGICAL SER							59
59.01 AMBULANCE							59.01
59.02 DAY TREATMENT							59.02
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-3025) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		532469			361757		1386 41
44 LABORATORY		532588			401662		700 44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		1225909			974789		49
50 PHYSICAL THERAPY		7256454			4042002		50
51 OCCUPATIONAL THERAPY		6431097			3903024		51
52 SPEECH PATHOLOGY		3046185			1577412		52
55 MEDICAL SUPPLIES CHARGED TO P		550754			300811		55
56 DRUGS CHARGED TO PATIENTS		3379484			2465050		14800 56
59 PSYCHIATRIC/PSYCHOLOGICAL SER		400954			265952		73 59
59.01 AMBULANCE		64841			31497		59.01
59.02 DAY TREATMENT							59.02
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		23420735			14323956		16959 101

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-3025)	[]	SUB IV	[]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[]	TITLE XIX	[]	SUB II	[]	NF		
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS					
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
59 PSYCHIATRIC/PSYCHOLOGICAL SER					59
59.01 AMBULANCE					59.01
59.02 DAY TREATMENT					59.02
OUTPATIENT SERVICE COST CENTERS					
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-3025)
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I
 BOXES [] TITLE XIX - O/P [] SUB II
 [] SUB III
 [] SUB IV

[] SNF
 [] NF
 [] S/B-SNF
 [] S/B-NF
 [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES			
	PART II	PART I	PART II	OUTPATIENT	OUTPATIENT	OTHER	
	COL. 8	COL. 9	COL. 9	AMBULATORY	RADIOLOGY	OUTPATIENT	
	1	1.01	1.02	SURGICAL	CENTER	DIAGNOSTIC	
				2	3	4	
41 ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC	.592215	.592215	.592215				41
44 LABORATORY	.070009	.070009	.070009				44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	.230911	.230911	.230911				49
50 PHYSICAL THERAPY	.269384	.269384	.269384				50
51 OCCUPATIONAL THERAPY	.225285	.225285	.225285				51
52 SPEECH PATHOLOGY	.233954	.233954	.233954				52
55 MEDICAL SUPPLIES CHARGED TO PAT	.501267	.501267	.501267				55
56 DRUGS CHARGED TO PATIENTS	.323492	.323492	.323492				56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.246285	.246285	.246285				59
59.01 AMBULANCE	.302602	.302602	.302602				59.01
59.02 DAY TREATMENT							59.02
62 OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINCT							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL							101
102 CRNA CHARGES							102
103 LESS BPB CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.323492	1
2 PROGRAM VACCINE CHARGES		2
2.01 PROGRAM VACCINE CHARGES		2.01
3 PROGRAM COSTS		3
3.01 PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-3025) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 * [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER	PPS SER- VICES	PPS SER- VICES	OUTPATIENT SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC
	(SEE INSTRU.) 5	(SEE INSTRU.) 5.01	(SEE INSTRU.) 5.02	(SEE INSTRU.) 5.03	(SEE INSTRU.) 5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC		1386						41
44 LABORATORY		700						44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY								49
50 PHYSICAL THERAPY								50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
55 MEDICAL SUPPLIES CHARGED TO PA								55
56 DRUGS CHARGED TO PATIENTS		14800						56
59 PSYCHIATRIC/PSYCHOLOGICAL SERV		73						59
59.01 AMBULANCE								59.01
59.02 DAY TREATMENT								59.02
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD								65.03
101 SUBTOTAL		16959						101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES		16959						104

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-3025) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		821					41
44 LABORATORY		49					44
46.30 BLOOD CLOTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO PAT							55
56 DRUGS CHARGED TO PATIENTS		4788					56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		18					59
59.01 AMBULANCE							59.01
59.02 DAY TREATMENT							59.02
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINCT							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL		5676					101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES		5676					104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	CAPITAL RELATED COST 1	SWING-BED ADJUSTMENT 2	REDUCED CAPITAL RELATED COST 3	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	REDUCED CAPITAL RELATED COST 6	
25 INPAT ROUTINE SERV COST CTRS ADULTS & PEDIATRICS				995508		995508	25
26 INTENSIVE CARE UNIT							26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL				995508		995508	101

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	PER DIEM 11	INPATIENT PROGRAM CAPITAL COST 12	
25 INPAT ROUTINE SERV COST CTRS ADULTS & PEDIATRICS	15833	530			62.88	33326	25
26 INTENSIVE CARE UNIT							26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL	15833	530				33326	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-3025) [] SUB III [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----		
	RELATED COST 1	RELATED COST 2			RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC		20288	532469	17487			.038102	666	41
44 LABORATORY		2048	532588	14514			.003845	56	44
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
49 RESPIRATORY THERAPY		9050	1225909	37160			.007382	274	49
50 PHYSICAL THERAPY		269996	7256454	269356			.037208	10022	50
51 OCCUPATIONAL THERAPY		144841	6431097	277054			.022522	6240	51
52 SPEECH PATHOLOGY		64567	3046185	120441			.021196	2553	52
55 MEDICAL SUPPLIES CHARGED TO P		35393	550754	17222			.064263	1107	55
56 DRUGS CHARGED TO PATIENTS		26171	3379484	103588			.007744	802	56
59 PSYCHIATRIC/PSYCHOLOGICAL SER		8543	400954	25840			.021307	551	59
59.01 AMBULANCE		274	64841	4150			.004226	18	59.01
59.02 DAY TREATMENT									59.02
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINC									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		581171	23420735	886812				22289	101

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01
 05/15/2009 14:43

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

	COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT					
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					15833		530	25
26	INTENSIVE CARE UNIT								26
27	CORONARY CARE UNIT								27
28	BURN INTENSIVE CARE UNIT								28
29	SURGICAL INTENSIVE CARE UNIT								29
30	OTHER SPECIAL CARE (SPECIFY)								30
31	SUBPROVIDER I								31
33	NURSERY								33
34	SKILLED NURSING FACILITY								34
35	NURSING FACILITY								35
101	TOTAL					15833		530	101

PROVIDER NO. 15-3025 HEALTHSOUTH DEACONESS REHAB
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.01
 05/15/2009 14:43

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-3025) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2.	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
59 PSYCHIATRIC/PSYCHOLOGICAL SER							59
59.01 AMBULANCE							59.01
59.02 DAY TREATMENT							59.02
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-3025) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH COSTS 3.01	CHARGES 4	COST TO CHARGES 5	RATIO OF COST TO CHARGES 5.01	PROGRAM CHARGES 6	PROGRAM PASS THROUGH COSTS 7	PROGRAM CHARGES 8
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		532469			17487		41
44 LABORATORY		532588			14514		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		1225909			37160		49
50 PHYSICAL THERAPY		7256454			269356		50
51 OCCUPATIONAL THERAPY		6431097			277054		51
52 SPEECH PATHOLOGY		3046185			120441		52
55 MEDICAL SUPPLIES CHARGED TO P		550754			17222		55
56 DRUGS CHARGED TO PATIENTS		3379484			103588		56
59 PSYCHIATRIC/PSYCHOLOGICAL SER		400954			25840		59
59.01 AMBULANCE		64841			4150		59.01
59.02 DAY TREATMENT							59.02
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		23420735			886812		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (15-3025)	<input type="checkbox"/>	SUB IV	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	SUB I	<input type="checkbox"/>	SNF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	SUB II	<input type="checkbox"/>	NF	<input type="checkbox"/>	OTHER
			<input type="checkbox"/>	SUB III	<input type="checkbox"/>	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
ANCILLARY SERVICE COST CENTERS					
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
59 PSYCHIATRIC/PSYCHOLOGICAL SER					59
59.01 AMBULANCE					59.01
59.02 DAY TREATMENT					59.02
OUTPATIENT SERVICE COST CENTERS					
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-3025) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II	PART I	PART II	OUTPATIENT	OUTPATIENT	OTHER
	COL. 8	COL. 9	COL. 9	AMBULATORY	RADIOLOGY	OUTPATIENT
	1	1.01	1.02	SURGICAL	CENTER	DIAGNOSTIC
				2	3	4
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	.592215	.592215	.592215			41
44 LABORATORY	.070009	.070009	.070009			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.230911	.230911	.230911			49
50 PHYSICAL THERAPY	.269384	.269384	.269384			50
51 OCCUPATIONAL THERAPY	.225285	.225285	.225285			51
52 SPEECH PATHOLOGY	.233954	.233954	.233954			52
55 MEDICAL SUPPLIES CHARGED TO PAT	.501267	.501267	.501267			55
56 DRUGS CHARGED TO PATIENTS	.323492	.323492	.323492			56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.246285	.246285	.246285			59
59.01 AMBULANCE	.302602	.302602	.302602			59.01
59.02 DAY TREATMENT						59.02
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTINCT						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65.01 AMBULANCE SERVICES (2ND PERIOD)						65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)						65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)						65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.323492	1
2 PROGRAM VACCINE CHARGES		2
2.01 PROGRAM VACCINE CHARGES		2.01
3 PROGRAM COSTS		3
3.01 PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-3025) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1) (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	ALL OTHER (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	410							41
44 LABORATORY	1366							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY								49
50 PHYSICAL THERAPY	130572							50
51 OCCUPATIONAL THERAPY	116652							51
52 SPEECH PATHOLOGY	73964							52
55 MEDICAL SUPPLIES CHARGED TO PA	723							55
56 DRUGS CHARGED TO PATIENTS	419							56
59 PSYCHIATRIC/PSYCHOLOGICAL SERV	272							59
59.01 AMBULANCE								59.01
59.02 DAY TREATMENT								59.02
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)								65.03
101 SUBTOTAL	324378							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	324378							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-3025) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST					HOSPITAL	HOSPITAL
	ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		243					41
44 LABORATORY		96					44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY		35174					50
51 OCCUPATIONAL THERAPY		26280					51
52 SPEECH PATHOLOGY		17304					52
55 MEDICAL SUPPLIES CHARGED TO PAT		362					55
56 DRUGS CHARGED TO PATIENTS		136					56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		67					59
59.01 AMBULANCE							59.01
59.02 DAY TREATMENT							59.02
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINCT							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL		79662					101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES		79662					104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-3025)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	15833						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	15833						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15833						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	11168						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	811						14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-3025)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	7187986						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7187986						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	10789115						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	675500						29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10113615						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.666226						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	638.77						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	7187986						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-3025)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	453.99					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	5070160					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	5070160					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (15-3025)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	3827876					48
49 TOTAL PROGRAM INPATIENT COSTS	8898036					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	702244					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	338478					51
52 TOTAL PROGRAM EXCLUDABLE COST	1040722					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	7857314					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-3025)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	PROGRAM DISCHARGES	1	1	1	1	54
55	TARGET AMOUNT PER DISCHARGE					55
56	TARGET AMOUNT					56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					57
58	BONUS PAYMENT					58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET					58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET					58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT					58.03
58.04	RELIEF PAYMENT					58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT					59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)					59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1					59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1					59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)					59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1					59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1					59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)					59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)					59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD					60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD					61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS					62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD					63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD					64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS					65

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68 PROGRAM ROUTINE SERVICE COST	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72 PER DIEM CAPITAL RELATED COSTS	72
73 PROGRAM CAPITAL RELATED COSTS	73
74 INPATIENT ROUTINE SERVICE COST	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78 INPATIENT ROUTINE SERVICE COST LIMITATION	78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV
 (PPS)
 (15-3025)
 1 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS		83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	453.99	84
85 OBSERVATION BED COST		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	HOSPITAL ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		7187986				86
87 NEW CAPITAL-RELATED COST	995508	7187986	.138496			87
88 NON PHYSICIAN ANESTHETIST		7187986				88
89 MEDICAL EDUCATION		7187986				89

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (15-3025)	SUB I	SUB II	SUB III	SUB IV	NF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	15833						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	15833						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15833						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	530						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (15-3025)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	7187983						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7187983						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	10789115						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	675500						29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10113615						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.666225						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	638.77						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	7187983						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (15-3025)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	453.99					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	240615					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	240615					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (15-3025)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	232870					48
49 TOTAL PROGRAM INPATIENT COSTS	473485					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	33326					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	22289					51
52 TOTAL PROGRAM EXCLUDABLE COST	55615					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (15-3025)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54	32					54
55						55
56						56
57						57
58						58
58.01						58.01
58.02						58.02
58.03						58.03
58.04						58.04
59						59
59.01						59.01
59.02						59.02
59.03						59.03
59.04						59.04
59.05						59.05
59.06						59.06
59.07						59.07
59.08						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60						60
61						61
62						62
63						63
64						64
65						65

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY NF

66	SNF/NF/ICF/MR ROUTINE SERVICE COST	1	66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68	PROGRAM ROUTINE SERVICE COST		68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72	PER DIEM CAPITAL RELATED COSTS		72
73	PROGRAM CAPITAL RELATED COSTS		73
74	INPATIENT ROUTINE SERVICE COST		74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78	INPATIENT ROUTINE SERVICE COST LIMITATION		78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80	PROGRAM INPATIENT ANCILLARY SERVICES		80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS		82

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (15-3025)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS

84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM

85 OBSERVATION BED COST

453.99

83

84

85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[] TITLE V [XX] HOSPITAL (15-3025) [] SNF [] PPS
 [] TITLE XVIII-PT A [] SUB I [] NF [] TEFRA
 [XX] TITLE XIX [] SUB II [] S/B-SNF [XX] OTHER
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
25 INPATIENT ROUTINE SERVICE COST CENTERS		406640		25
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	.592215	17487	10356	41
44 LABORATORY	.070009	14514	1016	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.230911	37160	8581	49
50 PHYSICAL THERAPY	.269384	269356	72560	50
51 OCCUPATIONAL THERAPY	.225285	277054	62416	51
52 SPEECH PATHOLOGY	.233954	120441	28178	52
55 MEDICAL SUPPLIES CHARGED TO PAT	.501267	17222	8633	55
56 DRUGS CHARGED TO PATIENTS	.323492	103588	33510	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.246285	25840	6364	59
59.01 AMBULANCE	.302602	4150	1256	59.01
59.02 DAY TREATMENT				59.02
OUTPATIENT SERVICE COST CENTERS				
62 OBSERVATION BEDS (NON-DISTINCT				62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC				63.50
63.60 FQHC				63.60
101 TOTAL		886812	232870	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		886812		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
DRG AMOUNT						
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1						1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT						2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD						3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.06
		[FOR CR PERIODS ENDING]				
		[ON OR AFTER 7/1/2005]				
		[E-3,PT.VI,LN.15][PLUS LN.3.06]				
3.07 SUM OF LINES 3.04-3.06		0.00		0.00		3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14 CURRENT YEAR ALLOWABLE FTE						3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
		RES. IN				
		INIT YRS				
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO				0.00		3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL SUB I SUB II SUB III SUB IV

3.18	CURRENT YEAR RESIDENT TO BED RATIO					3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO					3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19					3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1					3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1					3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]					3.23
3.24	SUM OF LINES 3.21-3.23	0	0			3.24
	DISPROPORTIONATE SHARE ADJUSTMENT					
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS					4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS					4.01
4.02	SUM OF 4 AND 4.01					4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317					5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317					5.01
5.02	DIVIDE LINE 5.01 BY LINE 5					5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317					5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK					5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS					5.05
5.06	TOTAL ADDITIONAL PAYMENT					5.06
6	SUBTOTAL					6
7	HOSPITAL SPECIFIC PAYMENTS					7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)					7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS					8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL					9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL					10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT					11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE					11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES					11.02
12	NET ORGAN ACQUISITION COST					12
13	COST OF TEACHING PHYSICIANS					13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS					14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					15
16	TOTAL					16
17	PRIMARY PAYER PAYMENTS					17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES					18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES					19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES					20
21	REIMBURSABLE BAD DEBTS					21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS					21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					21.02
22	SUBTOTAL					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					23
24	OTHER ADJUSTMENTS					24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					25
26	AMOUNT DUE PROVIDER					26
27	SEQUESTRATION ADJUSTMENT					27
28	INTERIM PAYMENTS					28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					28.01
29	BALANCE DUE PROVIDER (PROGRAM)					29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					30
	TO BE COMPLETED BY INTERMEDIARY					
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01					50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01					51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)					52
53	CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)					55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)					56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (15-3025) 1	HOSPITAL (15-3025) 1.01	HOSPITAL (15-3025) 1.02
1 MEDICAL AND OTHER SERVICES			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	5676		1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS			1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO	11201		1.03
1.04 LINE 1.01 TIMES LINE 1.03			1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04			1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT			1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101			1.07
2 INTERNS AND RESIDENTS			2
3 ORGAN ACQUISITIONS			3
4 COST OF TEACHING PHYSICIANS			4
5 TOTAL COST			5
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
6 ANCILLARY SERVICE CHARGES			6
7 INTERNS AND RESIDENTS SERVICE CHARGES			7
8 ORGAN ACQUISITION CHARGES			8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS			9
10 TOTAL REASONABLE CHARGES			10
CUSTOMARY CHARGES			
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			12
13 RATIO OF LINE 11 TO LINE 12			13
14 TOTAL CUSTOMARY CHARGES			14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST			15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			16
17 LESSER OF COST OR CHARGES			17
17.01 TOTAL PPS PAYMENTS	11201		17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (15-3025) 1	HOSPITAL (15-3025) 1.01	HOSPITAL (15-3025) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES AND COINSURANCE			18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01	2323		18.01
19 SUBTOTAL	8878		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	8878		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	8878		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS			27
27.01 REDUCED REIMBURSABLE BAD DEBTS			27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			27.02
28 SUBTOTAL	8878		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	8878		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	8878		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM			35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(15-3025)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1 STANDARD OVERHEAD AMOUNTS (ASC FEES)	1
2 DEDUCTIBLES	2
3 SUBTOTAL	3
4 80 PERCENT OF LINE 3	4
5 ASC PORTION OF BLEND	5
6 OUTPATIENT ASC COST	6
COMPUTATION OF LESSER OF COST OR CHARGES	
7 TOTAL CHARGES	7
CUSTOMARY CHARGES	
8 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10 RATIO OF LINE 8 TO LINE 9	10
11 TOTAL CUSTOMARY CHARGES	11
12 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14 LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT	
15 DEDUCTIBLES AND COINSURANCE	15
16 TOTAL	16
17 HOSPITAL SPECIFIC PORTION OF BLEND	17
18 ASC BLENDED AMOUNT	18
19 LESSER OF LINES 16 OR 18	19
20 PART B DEDUCTIBLES AND COINSURANCE	20
21 ASC PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(15-3025)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	PREVAILING CHARGES	1
2	62 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(15-3025)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	PREVAILING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (15-3025)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		10913552		8878
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 TO .05 PROVIDER .50 TO .51 PROGRAM .53 .54			3.01 3.02 NONE 3.03 3.04 3.05 3.50 3.51 NONE 3.52 3.53 3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		10913552		8878
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52			5.01 5.02 NONE 5.03 5.50 NONE 5.51 5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM		-58033	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		10855519		8878

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL (15-3025)	SUB I	SUB II	SUB III	SUB IV	
1						1
1.01						1.01
1.02	10810685					1.02
1.03	0.0214					1.03
1.04	404514					1.04
1.05	23371					1.05
1.06	11238570					1.06
1.07						1.07
1.08						1.08
1.09						1.09
1.10						1.10
1.11						1.11
1.12						1.12
1.13						1.13
1.14						1.14
1.15						1.15
1.16						1.16
1.17						1.17
1.18						1.18
1.19						1.19
1.20						1.20
1.21						1.21
1.22						1.22
1.23						1.23
1.35						1.35
1.36						1.36
1.37						1.37
1.38						1.38
1.39						1.39
1.40	43.259563					1.40
1.41						1.41
1.42						1.42
2						2
3						3
4	11238570					4
5	60611					5
6	11177959					6
7	147080					7
8	11030879					8
9	175360					9
10	10855519					10
11						11
11.01						11.01
11.02						11.02
12	10855519					12
13						13

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WORKSHEET E-3
PART I

MEDICARE PART A SERVICES - TEFRA

HOSPITAL SUB I SUB II SUB III SUB IV
(15-3025)

13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)					13.01
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					14
15	OTHER ADJUSTMENTS					15
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					16
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER	10855519				17
18	SEQUESTRATION ADJUSTMENT					18
19	INTERIM PAYMENTS	10913552				19
19.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					19.01
20	BALANCE DUE PROVIDER/PROGRAM	-58033				20
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					21
TO BE COMPLETED BY INTERMEDIARY						
50	ORIGINAL OUTLIER AMOUNT					50
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					52
53	OPERATING TIME VALUE OF MONEY (SEE INSTRUCTIONS)					53

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

		[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX			
		HOSPITAL (15-3025) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1
1	INPATIENT HOSPITAL/SNF/NF SERVICES	473485					1
2	MEDICAL AND OTHER SERVICES	79662					2
3	INTERNS AND RESIDENTS						3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						4
5	COST OF TEACHING PHYSICIANS						5
6	SUBTOTAL	553147					6
7	INPATIENT PRIMARY PAYER PAYMENTS						7
8	OUTPATIENT PRIMARY PAYER PAYMENTS						8
9	SUBTOTAL	553147					9
	COMPUTATION OF LESSER OF COST OR CHARGES						
10	ROUTINE SERVICE CHARGES	406640					10
11	ANCILLARY SERVICE CHARGES	1211190					11
12	INTERNS AND RESIDENTS SERVICE CHARGES						12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE						13
14	TEACHING PHYSICIANS						14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION						15
16	TOTAL REASONABLE CHARGES	1617830					16
	CUSTOMARY CHARGES						
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						18
19	RATIO OF LINE 17 TO LINE 18						19
20	TOTAL CUSTOMARY CHARGES	1617830					20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	1064683					21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						22
23	COST OF COVERED SERVICES	553147					23
	PROSPECTIVE PAYMENT AMOUNT OTHER THAN OUTLIER PAYMENTS						24
24	OUTLIER PAYMENTS						25
25	PROGRAM CAPITAL PAYMENTS						26
26	CAPITAL EXCEPTION PAYMENTS						27
27	ROUTINE SERVICE OTHER PASS THROUGH COSTS						28
28	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						29
29	SUBTOTAL	553147					30
30	CUSTOMARY CHARGES (TITLE XIX PPS COVERED)						31
31	LESSER OF LINES 30 OR 31	553147					32
32	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						33

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (15-3025) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
		1	1	1	1	1	1
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT						
	EXCESS OF REASONABLE COST						34
35	SUBTOTAL	553147					35
36	COINSURANCE						36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,						37
38	REIMBURSABLE BAD DEBTS						38
38.01	REDUCED REIMBURSABLE BAD DEBTS						38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)						38.02
39	UTILIZATION REVIEW						39
40	SUBTOTAL	553147					40
41	INPATIENT ROUTINE SERVICE COST						41
42	MEDICARE INPATIENT ROUTINE CHARGES						42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						44
45	RATIO OF LINE 43 TO LINE 44						45
46	TOTAL CUSTOMARY CHARGES						46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION						49
50	OTHER ADJUSTMENTS						50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS						51
52	SUBTOTAL	553147					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT						53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	553147					55
56	SEQUESTRATION ADJUSTMENT						56
57	INTERIM PAYMENTS	403145					57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						57.01
58	BALANCE DUE PROVIDER/PROGRAM	150002					58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2)						59

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2184518			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3545093			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1438194			6
7	INVENTORY	98330			7
8	PREPAID EXPENSES	89249			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	4478996			11
FIXED ASSETS					
12	LAND				12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS				13
13.01	ACCUMULATED DEPRECIATION				13.01
14	BUILDINGS				14
14.01	ACCUMULATED DEPRECIATION				14.01
15	LEASEHOLD IMPROVEMENTS	1435487			15
15.01	ACCUMULATED AMORTIZATION	-1339364			15.01
16	FIXED EQUIPMENT				16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	2145532			18
18.01	ACCUMULATED DEPRECIATION	-1318664			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	922991			21
OTHER ASSETS					
22	INVESTMENTS				22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	12307841			25
26	TOTAL OTHER ASSETS	12307841			26
27	TOTAL ASSETS	17709828			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	281248			28
29	SALARIES, WAGES & FEES PAYABLE	717897			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS	3592190			34
35	OTHER CURRENT LIABILITIES	1183319			35
36	TOTAL CURRENT LIABILITIES	5774654			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE				38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES				41
42	TOTAL LONG TERM LIABILITIES				42
43	TOTAL LIABILITIES	5774654			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	11935174			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	11935174			51
52	TOTAL LIABILITIES AND FUND BALANCES	17709828			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	11972797			1
2 NET INCOME (LOSS)	3553437			2
3 TOTAL	15526234			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6 MINORITY INTEREST				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	15526234			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13 MINORITY INTEREST	781756			13
14 DISTRIBUTIONS	2809304			14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS	3591060			18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	11935174			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				
2 HOSPITAL	10789115		10789115	1
4 SUBPROVIDER I				2
5 SWING BED - SNF				4
6 SWING BED - NF				5
7 SKILLED NURSING FACILITY				6
8 NURSING FACILITY				7
9 OTHER LONG TERM CARE				8
TOTAL GENERAL INPATIENT CARE SERVICES	10789115		10789115	9
10 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT				10
12 CORONARY CARE UNIT				11
13 BURN INTENSIVE CARE UNIT				12
14 SURGICAL INTENSIVE CARE UNIT				13
15 OTHER SPECIAL CARE (SPECIFY)				14
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16 TOTAL INPATIENT ROUTINE CARE SERVICES	10789115		10789115	16
17 ANCILLARY SERVICES	20452214		20452214	17
18 OUTPATIENT SERVICES		2968520	2968520	18
18.50 RHC				18.50
18.60 FQHC				18.60
19 HOME HEALTH AGENCY				19
20 AMBULANCE				20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24 PSYCH				24
24.04 NON-REIMBURSABLE PSYCH	10812	16107	26919	24.04
25 TOTAL PATIENT REVENUES	31252141	2984627	34236768	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		13290428	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		13290428	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	34236768	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	17604753	2
3	NET PATIENT REVENUES	16632015	3
4	LESS - TOTAL OPERATING EXPENSES	13290428	4
5	NET INCOME FROM SERVICE TO PATIENTS	3341587	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	67154	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	111847	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.01	OTHER OPERATING INCOME	32849	24.01
25	TOTAL OTHER INCOME	211850	25
26	TOTAL	3553437	26
27	OTHER EXP		27
27.02	CONTRACTED THERAPIST INCOME		27.02
28			28
29	TOTAL OTHER EXPENSES		29
30			30
31	NET INCOME (OR LOSS) FOR THE PERIOD	3553437	31

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - FULLY PROSPECTIVE METHOD

WORKSHEET L

HOSPITAL HOSPITAL SUB I SUB II SUB III
 1 1.01

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS				1
	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER				2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997				3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997				3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT				
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD [E-3,PT VI, LN.18] [E, PT A, LN.3.17] [x E-3,PT VI, LN.1]				4
4.01	NO. OF INTERNS & RESIDENTS	0.00			4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE				4.02
4.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT DISPROPORTIONATE SHARE ADJUSTMENT				4.03
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS				5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I				5.01
5.02	SUM OF LINES 5 AND 5.01				5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE				5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT				5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS				6

PART II - HOLD HARMLESS METHOD

1	NEW CAPITAL				1
2	OLD CAPITAL				2
3	TOTAL CAPITAL				3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL				4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE				5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT				6
7	REDUCED OLD CAPITAL AMOUNT				7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL				8
9	SUBTOTAL				9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)				10

PART III - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST				1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST				2
3	TOTAL INPATIENT PROGRAM CAPITAL				3
4	CAPITAL COST PAYMENT FACTOR				4
5	TOTAL INPATIENT PROGRAM CAPITAL COST				5

PART IV - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS				1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES				2
3	NET PROGRAM INPATIENT CAPITAL COSTS				3
4	APPLICABLE EXCEPTION PERCENTAGE				4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS				5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES				6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES				7
8	CAPITAL MINIMUM PAYMENT LEVEL				8
9	CURRENT YEAR CAPITAL PAYMENTS				9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS				10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT				11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS				12
13	CURRENT YEAR EXCEPTION PAYMENT				13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD				14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)				15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)				16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT				17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	4A	25	26	27
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES A					22
23 I&R SERVICES-OTHER PRGM COSTS A					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS					25
ANCILLARY SERVICE COST CENTERS					
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN CO					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
55 MEDICAL SUPPLIES CHARGED TO PAT					55
56 DRUGS CHARGED TO PATIENTS					56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI					59
59.01 AMBULANCE					59.01
59.02 DAY TREATMENT					59.02
OUTPATIENT SERVICE COST CENTERS					
62 OBSERVATION BEDS (NON-DISTINCT					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
98 PHYSICIANS' PRIVATE OFFICES					98
00 GUEST MEALS					00
00.01 MARKETING					00.01
00.03 NON REIMBURSABLE PSYCH					00.03
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 TOTAL					103
104 TOTAL STATISTICAL BASIS					104
105 UNIT COST MULTIPLIER					105
105 UNIT COST MULTIPLIER					105

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	70.54		3.35				73.89 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
41 RADIOLOGY-DIAGNOSTIC	67.94	0.26	3.28	0.08			71.56 41
44 LABORATORY	75.42	0.13	2.73	0.26			78.54 44
49 RESPIRATORY THERAPY	79.52		3.03				82.55 49
50 PHYSICAL THERAPY	55.70		3.71	1.80			61.21 50
51 OCCUPATIONAL THERAPY	60.69		4.31	1.81			66.81 51
52 SPEECH PATHOLOGY	51.78		3.95	2.43			58.16 52
55 MEDICAL SUPPLIES CHARGED TO PAT	54.62		3.13	0.13			57.88 55
56 DRUGS CHARGED TO PATIENTS	72.94	0.44	3.07	0.01			76.46 56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	66.33	0.02	6.44	0.07			72.86 59
59.01 AMBULANCE	48.58		6.40				54.98 59.01
101 TOTAL CHARGES	41.87	0.05	2.59	0.95			45.46 101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT						1
2	OLD CAP REL COSTS-MVBLE EQUIP						2
3	NEW CAP REL COSTS-BLDG & FIXT	1319361	9.50	-1319361	-15.42		3
4	NEW CAP REL COSTS-MVBLE EQUIP	399986	2.88	-399986	-4.68		4
5	EMPLOYEE BENEFITS	1701920	12.26	-1701920	-19.89		5
6	ADMINISTRATIVE & GENERAL	3299677	23.77	-3299677	-38.57		6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT	534094	3.85	-534094	-6.24		8
9	LAUNDRY & LINEN SERVICE	29618	.21	-29618	-.35		9
10	HOUSEKEEPING	164649	1.19	-164649	-1.92		10
11	DIETARY	447401	3.22	-447401	-5.23		11
12	CAFETERIA						12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION	225447	1.62	-225447	-2.64		14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY	178518	1.29	-178518	-2.09		17
18	SOCIAL SERVICE	254426	1.83	-254426	-2.97		18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES A						22
23	I&R SERVICES-OTHER PRGM COSTS A						23
24	PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	2228956	16.06	4959027	57.97	7187983	51.78
ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	201728	1.45	113608	1.33	315336	2.27
44	LABORATORY	21496	.15	15790	.18	37286	.27
46.30	BLOOD CLOTTING FACTORS ADMIN CO						46.30
49	RESPIRATORY THERAPY	151179	1.09	131897	1.54	283076	2.04
50	PHYSICAL THERAPY	781209	5.63	1173565	13.72	1954774	14.08
51	OCCUPATIONAL THERAPY	642568	4.63	806261	9.42	1448829	10.44
52	SPEECH PATHOLOGY	325789	2.35	386878	4.52	712667	5.13
55	MEDICAL SUPPLIES CHARGED TO PAT	136971	.99	139104	1.63	276075	1.99
56	DRUGS CHARGED TO PATIENTS	696892	5.02	396344	4.63	1093236	7.88
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	45360	.33	53389	.62	98749	.71
59.01	AMBULANCE	13844	.10	5777	.07	19621	.14
59.02	DAY TREATMENT						59.02
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC						63.50
63.60	FQHC						63.60
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY						69.30

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
NONREIMBURSABLE COST CENTERS							
98 PHYSICIANS' PRIVATE OFFICES	684		257334	3.01	258018	1.86	98
100 GUEST MEALS			75327	.88	75327	.54	100
100.01 MARKETING	23337	.17	18502	.22	41839	.30	100.01
100.03 NON REIMBURSABLE PSYCH	56520	.41	22294	.26	78814	.57	100.03
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	13881630	100.00	0	.00	13881630	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED COSTS 1	CHARGES 2	CAPITAL COST TO CHARGES 3	PROGRAM CHARGES 4	INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	20288	532469	.038102	361757	13784	41
44 LABORATORY	2048	532588	.003845	401662	1544	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	9050	1225909	.007382	974789	7196	49
50 PHYSICAL THERAPY	269996	7256454	.037208	4042002	150395	50
51 OCCUPATIONAL THERAPY	144841	6431097	.022522	3903024	87904	51
52 SPEECH PATHOLOGY	64567	3046185	.021196	1577412	33435	52
55 MEDICAL SUPPLIES CHARGED TO PAT	35393	550754	.064263	300811	19331	55
56 DRUGS CHARGED TO PATIENTS	26171	3379484	.007744	2465050	19089	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	8543	400954	.021307	265952	5667	59
59.01 AMBULANCE	274	64841	.004226	31497	133	59.01
59.02 DAY TREATMENT						59.02
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTINCT						62
OTHER REIMBURSABLE COST CENTERS						
63.50 RHC						63.50
63.60 FQHC						63.60
101 TOTAL	581171	23420735		14323956	338478	101

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	TOTAL COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
25	ADULTS & PEDIATRICS	995508		995508	15833	62.88	11168	702244 25
101	TOTAL	995508		995508			11168	702244 101

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS 702244

MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS 338478

TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS 1040722

MEDICARE DISCHARGES (WORKSHEET S-3, LINE 8, COLUMN 13)

MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 8, COLUMN 4)

PER DISCHARGE CAPITAL COSTS

PER DIEM CAPITAL COSTS

I. COST TO CHARGE RATIO FOR FREESTANDING IRF

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 8 LINES 25-30 + WKST D PART IV COL 7 LINE 101))	8898036
2. TOTAL MEDICARE CHARGES (WKST D-4 COLUMN 2 LINES 25-30 + LINE 103)	21933876
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.406

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 25-30, COLS 10 & 12 + WKST D PART II, LINE 101, COLS 6 & 8)	1040722
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	.047

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	5676
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	16959
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.335